



GENDER AND REPRODUCTIVE HEALTH POLICY IN MALAWI

Brief

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Background

The government of Malawi is currently undergoing significant transformation in national policies, stewardship, and commitments for family planning and gender equality. Targeted advocacy has helped increase funding for family planning and led to the addition of a family planning line item in the national budget (HPP, 2013). Malawi’s recently passed *Marriage, Divorce and Family Relations Bill* represents a policy milestone for family planning and gender equality advocates. Specifically, it acknowledges the negative health implications of early marriage and establishes age 18 as the minimum legal age for all statutory and customary marriages. The national Ministry of Gender, Children, Disability and Social Welfare (MOGCDSW) also recently launched a new institutional policy and five-year strategic plan, which sets forth ambitious targets and establishes the ministry’s central role in addressing gender-based violence (GBV) (MOGCDSW, 2014).

The Health Policy Project (HPP), with support from USAID and in cooperation with national policymakers

and advocates, undertook a systematic assessment to better understand and document this dynamic policy environment, as well as the challenges and opportunities Malawi faces in implementing more gender-responsive population and family planning policies. The assessment included a desk review of current policies and a series of key informant interviews that sought to (1) assess the role and impact of gender stewardship mechanisms on population and family planning-related policies and programs and (2) document first-hand perspectives on policy implementation.

Methods

Using a policy assessment checklist that drew from tools previously developed by HPP, the World Health Organization, and the Pan-American Health Organization, HPP systematically reviewed 20 key policies that directly or indirectly affect gender equality, health, population, and family planning. In Malawi, most family planning-related policies are reflected

within national sexual and reproductive health (SRH) policies and programs. The policy documents reviewed included national laws, policies, strategic plans, and implementation guidelines. Policies addressing youth and education sector activities were also reviewed based on their attention to youth-oriented interventions around sexual and reproductive health. Some of the policies reviewed were in draft form—another indication of the currently changing policy environment. A full list of policies reviewed, in order of gender responsiveness ranking, is appended.

To complement the policy review, we interviewed 15 policymakers, civil society representatives, donors, development partners, and other experts working on gender and SRH policy development, implementation, or advocacy in Malawi. The interviews provided additional qualitative perspectives on institutional relationships; the extent to which gender guidelines and expertise are reflected in population and family planning policy and program development, implementation, and monitoring; perceived gaps in capacity; and recommendations for moving forward. Key questions addressed the following topics:

- The mandates, responsibilities, and resources allotted to gender focal points and decisionmakers in the Ministry of Health (MOH), MOH Reproductive Health Directorate (RHD), and the MOGCDSW
- The presence and efficacy of formal and informal collaboration mechanisms among these entities to integrate gender into SRH policies and programs
- How gender focal points navigate competing priorities and responsibilities
- Current capacity-strengthening initiatives, and recommendations for strengthening human resource capacity in gender
- Monitoring and evaluation systems, and documentation of best practices in implementation
- The role of non-state actors in financing, developing, implementing, and monitoring gender-responsive SRH programs

Box 1. Key characteristics of gender-responsive policies

- **Participation/consultation:** Gender experts, along with relevant beneficiary groups, were consulted as a part of the policy formulation process.
- **High-level gender equality priorities:** An explicit commitment to promoting gender equality or reducing gender inequities is indicated within the policy's vision, goals, or principles.
- **Sex-disaggregated data:** Collection of sex-disaggregated data is included in the policy monitoring and evaluation plan and used to identify key gender issues and inequities.
- **Gender-sensitive situation analysis:** Policy's priorities and situation analysis reflect an understanding of gender equality as a health determinant and acknowledge gender-based constraints in access to health services.
- **Gender-responsive policy objectives and lines of action:** Specific strategies are proposed to reduce gender-based inequalities and to address the differential needs of women and men and girls and boys. These may include but are not limited to:
 - Explicit protections against gender based discrimination and harmful practices such as GBV, child marriage, or female genital cutting
 - Promotion of male involvement in family planning/SRH
 - The elimination of eligibility barriers—such as marital status, spousal consent, or age—for use of family planning and reproductive health services
 - Privacy and confidentiality protections
- **Consistency and alignment across policies:** Policy language clearly aligns with, or expresses intention to align with, current national gender guidelines and strategies.

Gender and SRH Policy Assessment

Among the health and population-focused policies we reviewed, we found that two meet the most criteria for gender-responsiveness (Box 1, p. 2): the *National Plan of Action for Scaling up SRH and HIV Prevention Initiatives for Young People* (2008) and the *National Population Policy* (2012). The least gender-responsive were *Clinical Management of HIV in Children and Adults* (2014 guidelines including integrated HIV services in family planning, antenatal care, and maternity care) and *Guidelines for Community Initiatives for Reproductive Health* (2007).

Alignment of policy language and priorities

More recently drafted, high-level national health policies—particularly those focused on SRH—suggest an aspiration to align with national and international gender equality and human rights standards. Even so, direct alignment through common language, standards, or priorities is not evident across documents. Gender-focused policies are inconsistent in their attention to sexual and reproductive health. The *National Gender Policy* (draft, June 2014) gives more attention to HIV and AIDS—a health area where the MOGCDSW has been more active—than to family planning and reproductive health. The 2013 *Gender Equality Act* makes stronger references to linkages between gender and SRH, and the MOH RHD was involved in its drafting; but according to stakeholders, the stipulations of this law are not yet well-known or operationalized.

Among the gender-related issues most commonly referenced among policy priorities and action items are GBV and harmful cultural practices, such as early marriage (Box 2). Policies that focus on these issues also reflect the clearest opportunities and mandates for multisectoral engagement—not only by gender and health ministries, but also more broadly. The *National Guidelines for Provision of Services for Physical and Sexual Violence*, for example, documents a specific, signed commitment by the MOGCDSW, MOH, police, and judiciary to support its implementation within their respective sectors.

Box 2. Common policy priorities

Gender-focused policies, such as the *National Gender Policy* and *Gender Equality Act*, do establish **policy links between gender equality and sexual and reproductive health priorities**, though not with significant detail. The most commonly referenced gender and health priorities and interventions among all policies reviewed were in the areas of **gender-based violence** and **reduction of harmful cultural practices** and **male involvement** in SRH or women and girls' empowerment. Seventeen of the 20 policies reviewed addressed GBV or other harmful practices, such as early marriage, and 12 addressed the need for male involvement. These areas were more strongly evident in high-level policies rather than implementation guidelines, and were generally not well-defined.

Engagement of gender experts and champions in policy development

In most instances, outside of gender-focused policies, there is no clear indication in the text that gender experts—whether from civil society, development partners, or other government representatives—were consulted as a part of the policy development process. Only two of the health-focused policies we reviewed explicitly acknowledge the role of the gender ministry or other gender advocates. The *National Plan of Action for Scaling up SRH and HIV Prevention Initiatives for Young People* (2008–2012) explicitly notes the participation of the then Ministry of Gender and Community Services. The *National Guidelines for Provision of Services for Physical and Sexual Violence* (draft, October 2014) acknowledges the then Ministry of Gender, Women and Child Development for its technical inputs and lists the current MOGCDSW among four ministerial signatories to the guideline. However, the latter—as is the case with most clinical or service focused guidelines reviewed—fails to reflect any gender-specific issues or needs with respect to service provision.

Gaps in health sector-specific operational guidance on gender

Importantly, no health sector-specific gender guidelines exist—a concern that was echoed among a number of the Malawi-based gender experts and advocates we interviewed. Programmatic guidance for the implementation of gender-focused interventions is weak or nonexistent. Clinical- and community-level guidelines, in particular, are often gender-blind. Thus, for example, while male involvement in family planning emerges as a more commonly referenced strategic approach in policies, such as the *National Population Policy* (2012), few of the policies include any detail on what constitutes a male involvement intervention, or any guidance for implementation.

Policy monitoring and use of sex-disaggregated data

Another gap across policies was the failure to systematically use sex-disaggregated data or apply gender analysis to health priority areas in order to inform policy objectives or interventions. This gap was also evident in policy monitoring, as only a few policies reviewed specifically call for collection of sex-disaggregated data as part of the policy monitoring and evaluation framework.

Institutional Arrangements, Coordination, and Capacity

Despite a lack of clear implementation guidance and some inconsistency across policy documents, the policy assessment suggests a growing drive to link gender equality with SRH programming. This is particularly true among higher-level policies and around target issues. However, among individuals within the MOH and other key civil society and health sector stakeholders, there is only a tenuous understanding of the current leadership and coordination mechanisms for gender integration. HPP spoke with key civil society stakeholders and policymakers working in these areas to gain a better understanding of how those responsible for decision making and implementation understand their roles and coordinate with one another to address gender inequities as a part of SRH policy implementation.

Gender and reproductive health within the MOH

In recent years, it has been understood that the responsibility for gender integration within the MOH rests with the RHD. Initially, different officers represented the RHD in meetings on gender-related issues on an as-needed basis. The RHD director then appointed a gender focal point in an effort to locate responsibility for gender-equality programming and integration with one person, though not all other departments have been aware of that individual's appointment.

While acknowledging its *de facto* responsibility for gender, the RHD has not fully institutionalized that responsibility in a manner that allows gender to be addressed as a priority issue. The gender focal point also serves as the person responsible for technical oversight for the female condom program. That and other RHD program activities often take precedence given the competing priorities on the gender focal point's time. She, along with other stakeholders interviewed, stressed the challenge of merging the two roles in light of competing responsibilities and RHD program priorities. Gender is viewed as an ad-hoc responsibility, even as others in the ministry look to the RHD and the gender focal point to provide gender training and guidelines for health sector program implementers.

The United Nations Population Fund (UNFPA) -supported Gender Equity and Women Empowerment (GEWE) initiative has recently worked to place another individual within the Department of Planning to increase attention to gender at that level, and thus more effectively influence gender integration in MOH planning (Box 3, p. 5). This change has also enabled the current RHD gender focal point to participate in some higher level planning meetings. However, a long-term, formal division of responsibilities and the relationship between the two positions is not well-understood among MOH stakeholders.

Gender and health ministry coordination

At the central level, the MOGCDSW's mandate includes to “promote gender equality and safeguard

Box 3. Building commitment and capacity from the top down

The UNFPA-funded GEWE initiative has worked through the MOGCDSW not only to strengthen the role of individual gender focal points, but also to enhance capacity, commitment, and sustainable processes for gender integration among senior ministry officials. Targeting four sectors for support, including health, the program has sought to expand the sense of individual responsibility and understanding of gender beyond the ministries' overburdened gender focal points, who typically are not positioned to influence high-level policies and planning.

In the health sector, this means building a team of gender facilitators comprised of governmental officials and civil society representatives. These facilitators are leaders in the sector and include MOH directors, representatives of the National AIDS Commission, and departments of nutrition and orphans and vulnerable children. The Malawi Health Equity Network leads the civil society representatives, who are organized by constituency. The initiative provides experiential training to departmental directors and planning officers to review policies, budgets, and performance assessment tools in order to identify gaps and better institutionalize gender from the top down. The facilitation team will ultimately be charged with taking the lead to train their respective departments and colleagues to address gender in their own work. With an aim of elevating gender coordination and leadership more closely with the Department of Planning, GEWE worked directly with that department to strengthen gender coordination and to ensure the current gender focal point (located within the RHD) is involved in planning meetings.

The approach is promising, but with short-term funding for the initiative coming to an end in 2015, its success requires strong mentoring and training resources.

the welfare and participation of women in the social, political, and economic development process” (MOGCDSW, 2014, p. 8). It is charged with playing a leadership and coordinating role with other sectors—

including health—to integrate gender into their programming and to lead relevant cross-sectoral initiatives, particularly in the area of GBV.

The mandate of the MOGCDSW's Department of Gender Affairs also includes addressing commitments from the International Conference on Population and Development. It is thus directly involved in some SRH policies and programs, including a joint initiative with the RHD to train community development assistants to identify women with fistula and help them obtain appropriate services. One key area of collaboration between the MOGCDSW and the MOH has also been an ongoing effort to improve collection and use of sex-disaggregated data.

GBV and youth-centered programs and initiatives have offered additional opportunities for ministerial collaboration—both at the policy and planning levels through multisectoral technical working groups, and at the community and service-delivery levels. At the community and service-delivery levels, ministries have collaborated through One-Stop Centres—where the MOH and MOGCDSW have conducted joint trainings; and through district-level youth meetings that are the product of collaboration among district health, gender, and youth officials to address issues of adolescent pregnancy and keeping girls in school.

Such programs, however, are not necessarily indicative of a strong coordination mechanism between ministries. Respondents spoke to a need for a stronger sense of mutual support and negotiation around roles, resources, and priorities among the MOH and MOGCDSW. For example, the Department of Gender Affairs is one of several ministerial departments—a structure that has at times complicated institutional coordination with the MOH. Within the health ministry, the RHD gender focal point is expected to ensure multisectoral representation at meetings addressing gender issues—a responsibility typically understood to rest with the MOGCDSW. One respondent pointed to delays in the implementation of a joint GBV activity due to “funding and incentive issues.” Multisectoral technical working groups are well-established on paper, but in practice, as one respondent noted, “To say that a technical working group is ‘working well’ may simply mean that it is meeting at all.”

Making the case for gender: increasing capacity and influence

A common concern raised among interviewees was the need for greater technical capacity and influence of gender focal points—not only in the health sector, but also across ministries and departments. A significant barrier to gender integration in sector- or department-specific planning is a lack of understanding or clear internal messaging around what it means to integrate gender into health programs. Many MOH staff never received more than two hours of training on gender concepts. Gender integration is frequently viewed as an elite or theoretical agenda or as limited to promoting women’s political empowerment. The 2014 draft *National Gender Policy* itself points to gaps in understanding and capacity to address gender, stating, “At [the] institutional level, there are also a lot of challenges and key among them is the limited gender mainstreaming capacities across sectors; inadequate resource allocation; and misconceptions and misunderstanding of the meaning of gender in the communities” (MoGCDSW, 2014, p. 9).

One donor representative pointed to plans by the MOGCDSW to strengthen gender focal point capacity in these areas. However, she further emphasized that equally problematic is a lack of seniority among any gender focal points within their respective ministries or departments and that the focal points are responsible for multiple program areas. Another noted, “Most of the gender focal point positions are given to women, and generally at a level where they cannot influence policy and do not have decision-making power.”

Malawi-based gender specialists are actively involved in a number of donor-supported programs to strengthen gender integration and capacity, including within the health sector. However, rather than working directly within a government ministry, these specialists are more likely to work in donor-funded positions, often consultants for finite projects. Donor-funded gender focal points that are seconded to ministries may have stronger capacity in gender analysis and integration, but they are not positioned to have meaningful influence over broader budgeting and planning priorities.

Policy Implementation, Resources, and Monitoring

Stakeholders repeatedly pointed to the gap between the vast policy environment around gender and SRH and the implementation of those policies. Effective implementation of gender-responsive health policies and programs requires not only commitment, capacity, and sustained attention at the highest levels of health sector planning but also financial resources to support those efforts.

Financing gender policies and programs

Limited financing for gender programs and integration, coupled with a lack of understanding or guidance on *how* to budget for gender, means that in practice, gender has not been a consideration in the budgeting process. Previous gender-responsive budgeting (GRB) initiatives between 2003 and 2005 did not ultimately translate into targeted funding for gender programs. Gender mainstreaming guidance issued by the gender ministry was not sector-specific, leaving no practical guidance or planning for gender to which sector budgets could be linked. The Ministry of Finance and Economic Development has only recently begun recommending that other ministries institute GRB processes, but planners were not notified of any new GRB guidelines (MOGCDSW, 2014; Mbilizi, 2013). At the time of this assessment, some stakeholders indicated an awareness that the finance ministry was in the process of developing formal GRB guidelines, but they were not yet final.

Stakeholders interviewed valued the contributions of donors to gender integration and capacity development initiatives, such as the comprehensive, UNFPA-funded GEWE program, but voiced concern about how such programs can also limit internalization and systematization of gender integration among policymakers. Current government resources are insufficient to sustain gender programming either centrally or integrated into health sector programs. Much of the donor funding that is dedicated to gender integration and capacity strengthening is directed primarily through the MOGCDSW, rather than

across ministries. That said attention is shifting to the promotion of sustainability by engaging higher level decisionmakers and planners.

Moving from policy to implementation, and understanding what works

Although gaps exist between policy and implementation, some promising examples of progress and opportunities for learning are evident in youth-centered service delivery and community outreach programs (Box 4). Malawi's "youth bulge"—over 60 percent of the population is under the age of 24 (National Statistical Office and ICF Macro, 2011)—means that there is a significant need and opportunity to reach both young women and men through SRH and family planning services. Interventions at this level are more likely to be multisectoral, and cut across issues of women and girls' empowerment, preventing and responding to GBV, and promoting male involvement.

Even where such programs exist, systematic assessment and use of evidence at the central level to document what does and does not work are lacking. To bridge the gaps in implementers' understanding of what gender-responsive SRH programs look like in practice, documentation and dissemination of best practices is needed. Currently, this information is not readily available to other implementers. One interviewee observed that the only way to learn about effective programs is if "you know the person who knows the person who knows the person who did it." Multiple stakeholders interviewed also pointed to the need for stronger, more gender-responsive policy monitoring and evaluation frameworks—mechanisms that are essential for holding policymakers and implementers accountable for the commitments laid out in high-level strategies and for capturing the necessary evidence to inform future programming and implementation guidance.

Recommendations

While Malawi's gender and SRH policy landscape is robust, it remains incomplete and coordination is weak. An understanding of, and commitment to,

Box 4. Establishing comprehensive programs at the community level

At the community level, service providers such as the Family Planning Association of Malawi (FPAM) emphasize accessibility, equity, and stigma-free family planning services through "Youth Life Centres," mobile family planning clinics, and existing community institutions. FPAM endeavors to work directly with district health offices so their work complements, rather than competes, with public services. While FPAM has not historically worked directly with the MOGCDSW, it is currently working with the Ministry of Education on a project advocating for girls' education and basic sexuality education. Programs such as these, along with FPAM's work with the Teachers' Union of Malawi to integrate comprehensive sexuality education into teacher training programs, are important for meeting the resistance that remains to family planning programs and services at the community level and in schools.

At the community level, promoting male involvement in family planning is also an important strategy for reducing gender-based violence, but longstanding cultural gender norms remain a barrier. By advocating with community leaders and working with men to become more supportive of their partners' family planning choices, implementers like FPAM hope to reduce intimate partner violence and minimize women's fear that they must seek family planning services in secret.

strengthening the integration of gender in Malawi's SRH policies and programs is evident within many of the country's more recent, high-level policies, even if not consistently aligned or addressed across all SRH policies and guidelines. Stakeholders interviewed for this assessment offered numerous technical and operational insights and are themselves representative of the existing human capacity to lead strategic thinking and capacity development for strengthened gender integration. The challenge to policymakers and gender champions is to harness those strengths and address existing gaps in a manner that builds capacity and systems for implementation of strong gender and SRH

policies and programs, rather than adding additional policies that offer broad strategic direction or vague guidance. These stakeholders must work together to

- Provide clear implementation guidance at the policy level, including specific approaches in male involvement in family planning and SRH
 - Clarify roles and responsibilities for implementation, coordination, and monitoring both within the MOH and between the health sector and MOGCDSW
 - Develop more gender-sensitive clinical guidelines
 - Improve use of sex-disaggregated data and inclusion of gender-sensitive indicators in monitoring and evaluation frameworks
 - Utilize country-specific gender analyses to identify current needs and priorities and inform programs and strategies
 - Document challenges, promising practices, and potentially scalable multisectoral initiatives around priority gender and health programs
- Refine gender trainings to make them more in-depth, sustained, and appropriate—not only for current gender focal points, but also for all health sector actors
 - Monitor and sustain current initiatives to strengthen capacity and commitment to gender, including those focused on galvanizing understanding and commitment among high-level planners and decisionmakers
 - Develop a comprehensive approach to gender integration and coordination to ensure that when gender is included at the policy development stage, it is also included in program budgets and implementation
 - Mobilize domestic resources to cultivate sustained national resources, planning, and programs, including better incentives to hire directly and retain full-time gender experts, and the provision of gender budgeting guidelines to guide ministry and departmental plans

Annex A. Policies Reviewed

Policy name, ranked from most gender-responsive priorities and SRH strategies to least

- 1 National Gender Policy, draft (finalization anticipated 2015)
- 2 National Plan of Action to Combat Gender-Based Violence in Malawi, 2014–2020, draft (finalization anticipated 2015)
- 3 National Plan of Action for Scaling up SRH and HIV Prevention Initiatives for Young People, 2008–2012
- 4 National Population Policy, 2012
- 5 Malawi Health Sector Strategic Plan, 2011–2016
- 6 Community Based Injectable Contraceptive Services Guidelines, 2008
- 7 Malawi Growth and Development Strategy II, 2011–2016
- 8 Ministry of Gender, Children, Disability and Social Welfare Strategic Plan, 2014–2019¹
- 9 National Youth Policy, 2013
- 10 Guidelines for Family Planning Communication, 2011
- 11 National Sexual and Reproductive Health Policy, 2009
- 12 National Sexual and Reproductive Health and Rights Strategy, 2011–2016
- 13 Gender Equality Act, 2013
- 14 Advocacy and Communication Strategy for Sexual and Reproductive Health Rights, 2009, draft²
- 15 National Education Sector Plan, 2008–2017
- 16 National Guidelines for Provision of Services for Physical and Sexual Violence, 2014
- 17 Sexual and Reproductive Health and Rights and HIV and AIDS Integration Strategy for Malawi, 2015
- 18 Constitution of the Republic of Malawi, 1994
- 19 Guidelines for Community Initiatives for Reproductive Health, 2007
- 20 Clinical Management of HIV in Children and Adults, 2014

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Notes

- 1 The policy assessment tool included a series of questions, specifically addressing integration of gender into family planning and reproductive health—specific policy priorities and interventions. Where no such priorities or interventions were clearly articulated, these questions were scored as “not applicable.” As such, some gender-focused policies that did not specifically reference gender in the context of health or family planning and reproductive health received a lower overall ranking.
- 2 While this policy does not reflect a high level of gender-responsiveness, HPP learned during stakeholder interviews that the more recent, and more gender-responsive, *Guidelines for Family Planning Communications* (2011) was made a priority over the draft *Advocacy and Communication Strategy*.

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